DME Task Force Meeting

OCTOBER 15, 2014

Location: North Dakota State Capitol in Bismarck
Judicial Wing 2nd Floor - AV room 212

Time: 1:30 p.m. to 3:30 p.m.

Medical Services General Statement: The main purpose of the DME Task Force Meeting is to be a working group to discuss current policy and to bring recommendations to the table for Medical Services to take into consideration. It is not meant to discuss individually denied cases. The Department's decisions are based on 42 CFR 440.230(d) and the North Dakota Administrative Code 75-02-02-08, which allows the Department to place appropriate limits on services based on such criteria as medical necessity or utilization control procedures.

Attendance:
Jeanne Folmer – Sanford Health
Cindy Matson – Sanford Health
Mary Jo Henne – Sanford Health
Bruce Mettin – Trinity
Carrie Olivier – Altru/Yorhom
Brenda Schultz – Altru/Yorhom
Pat Greenfield – MedQuest
Barb Stockert – Sanford HCA
Gail Urbance – MedQuest
Brandy Burg – MedQuest
Hilda Miller – Sanford HCA
Linda Skiple – Sleep Easy Therapeutics
Lanae Fritel – HAMC
Sarah Christenson – HAMC
Andrew Wood - CHI
Tammy Zachmeier – Medical Services
Tammy Holm – Medical Services
Jennifer Sands – Medical Services
Nikki Lyons – Medical Services

Respiratory Assist Device

1. Please review documentation from your manual regarding the requirements on coverage for a Respiratory Assist Device.

   The PAP Policy allows coverage for a BiPAP (E0470) most often when a CPAP has been tried and failed. For both the CPAP and BiPAP to be covered in this policy the patient must have the diagnosis of 327.23. There are no exceptions to this.

   The RAD Policy was separated from the PAP policy way back in 2000. The reason for this was that patients were found to need a BiPAP or RAD for other reasons than OSA. Since these were separated most all other insurance carriers consider this policy independent from the CPAP policy.

The symptoms for needing the machine are listed. In addition to those one of the following diagnoses must be applicable. This is fine but then it states that a patient has to have OSA in addition to all of these.

It is highly unlikely a patient would have a disease such as ALS or COPD and also have OSA.

Finally the next paragraph goes on clarify that an E0471 is never covered if the primary dx is OSA.

Because of the way the manual is worded it is extremely unlikely that anyone would ever qualify for a RAD device. We feel that the paragraph regarding OSA needs to be removed from this policy. As mentioned above it would be very unlikely for an ALS or COPD patient to also have OSA but it is very likely that their disease alone would require the use of a RAD device.

Response:

The Department reviewed the current policy and the following changes have been implemented. The Respiratory Assist Device policy changes are highlighted below. Notices will be posted on Provider Updates and the DME manual will also be updated with an effective date of Oct. 1st, 2014.

Respiratory Assist Devise

Coverage allowed if one of the following conditions is present:

- Symptoms characteristic of sleep-associated hypoventilation, such as daytime hyper somnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc.

- Restrictive thoracic disorders (i.e., progressive neuromuscular diseases or severe thoracic cage abnormalities), severe chronic obstructive pulmonary disease, central sleep apnea or obstructive sleep apnea and the patient's oxygen saturation drops below 88% on room air.

- Obstructive sleep apnea (OSA): AHI is greater than or equal to 15 events per hour, or the AHI is 5 to 15 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia, or Hypertension, ischemic heart disease, or history of stroke and a single level device (E0601) has been tried and proven ineffective.

- An E0471 is not medically necessary if the primary diagnosis is OSA as the backup rate feature for a bi-level PAP device is of no proven value for the primary diagnosis of OSA and therefore will be considered experimental and investigational.

Denial for Alternate Funding

1. ND Medical Assistance publishes a non-covered or excluded list for a number of products. Often there are items that your department will not cover, which are not included on the list. Ex: custom highchair.

   We recently had a situation with this and the parent was only trying to seek alternate funding. We knew this would not be covered by ND Medical Assistance and told the customer this up front but the alternate payer needed an actual denial in writing.

   We tried submitting a prior and only received back a note stating that ND Medical Assistance will not give a denial for alternate funding.

   We totally understand your department is the payer of last resort, but this was an item no one ever expected you to cover. The customer just needed a denial in writing to show the alternate funder that this would not even be considered by your department. In the future what process should we use?

   Response:

   The Department recommends providers provide recipient with documentation supporting the non-coverage of the item (Provider manuals, Department notices and/or bulletins) as stated in the DME Manual on page 15 to utilize for alternative funding.

   Additional Discussion:

   Providers can refer the alternate funding representative to the Department for a verbal denial.

Prior Authorization/Adjustment Questions

1. When submitting an adjustment and I had received two PA numbers for one order, can I include both PA numbers on one adjustment or do I need to complete an adjustment for each PA received even though it was originally all on one order?

   Response:

   The Department asks that a separate adjustment request be submitted for each prior authorization number to insure the correct prior authorization will be adjusted.

2. What is the proper way to respond or resubmit a denied prior? Sometimes we resubmit the entire prior with additional documentation and we will get it back asking us to complete as an adjustment form. The adjustment form guide states that doing an adjustment on a denied prior is not allowed. What procedure would you like us to follow?

Response:

If the prior authorization was denied with the denial code D41 the provider may submit an adjustment with comments stating what requires adjusting. The Department reminds providers to submit all documents originally submitted.

If the prior authorization was denied with the denial code D88 (non-covered service or the statement concerning inserts for flat feet not covered) an adjustment is not appropriate. The provider may re-submit a prior authorization within 30 days of the denial, requesting reconsideration along with all documents originally submitted and any new documents if available.

3. Presently NDMA has a policy that states prior authorization is necessary for an item that is over $750 even if it is not listed on the fee schedule as requiring one. Could you please clarify if the prior is for single lines items or for an entire order? Example being if we have two braces and each one is for $500, would a prior be necessary even though the single items are not over $750 but the order is.

Response:

1920 - HCPCs Level II Resource Manual identifies this code per foot

North Dakota Purchase Fee Schedule:

L1920 - ANKLE FOOT ORTHOSIS, SINGLE UPRIGHT WITH STATIC OR ADJUSTABLE STOP (PHELPS OR PERLSTEIN TYPE), CUSTOM-FABRICATED

NO CMN required No Prior Auth. Required Medicaid Fee - $419.50

Examples:

1. A right L1920 is ordered, the provider references the North Dakota Purchase Fee Schedule.

   The Fee Schedule shows the code to be per foot which equals one unit.

   The code does not require prior authorization and the reimbursement fee is $419.50.

   The provider can submit to claims for payment as one unit for L1920 is less than $750.

2. A right and left L1920 is ordered, the provider references the North Dakota Purchase Fee Schedule.

   The Fee Schedule shows the code to be per foot which equals one unit.

The code does not require prior authorization and the reimbursement fee is $419.50.

The order is for a right and left L1920 which equals 2 units. The total reimbursement fee is $839.00.

The provider will need to submit a prior authorization for approval as 2 units of L1920 total cost is more than $750, according to the DME Manual page 81;

Appendix E – Prior Approval Always Required:

- Equipment or supplies at or above $750
- Estimated annual cumulative supplies of $750 or more per year

Providers need to make sure that they are requesting the appropriate number of units on the prior authorization and/or claim. Providers must make sure to request 2 units if dispensing both a left and right in order to be reimbursed correctly.

Breast Pump

1. As a provider, I was able to find a breast pump which is a quality pump but does not include the bag or cooler. It is very basic and it appears we can purchase them for around NDMA reimbursement price. I truly believe that if NDMA would increase their reimbursement a little…it would be a win-win. They want the mom's to work but yet they are supposed to get by with a hand pump? The mom is probably not going to do that. It seems there is more and more research showing there are benefits to children that are receiving breast milk.

Response:

The Department has reviewed and will increase HCPC E0603's reimbursement to $105.83 effective 7-1-14.

Low-profile G-tube B4088

1. I have a question regarding reimbursement for G-tube HCPCS B4088. We have a gentleman that uses one of these tubes. Our cost is $118.75 (which is very reasonable cost compared to our other vendors) but our reimbursement on that item is $39.55. Is there any plan to revisit and evaluate reimbursement on this code?

Response:

The Department will continue to reimburse the low-profile at the same rate as the standard as the low-profile is not considered medically necessary.

Sanford Health Medicaid Expansion

1. We are seeking clarification on the Sanford Health MA replacement plan. We do insurance verification on all transactions and we have examples of verifying insurance and patient has the Sanford Health MA replacement plan and when we file the claim it states they do not have coverage. When we contacted the Sanford Health MA replacement plan we were told that they do not always have updated information from the state. This makes it very difficult to serve the customer, provide equipment and get paid as rules and regulations are different for all insurances and if they are not followed up front the provider is often left with the cost. Is there a system in place to be sure the Sanford Health MA replacement plan has all correct information?

   Response:

   The Department recommends providers to first contact Sanford Health Medicaid Expansion at 1-855-305-5060 with this issue to allow them to look into this issue regarding the enrollment file. If there continues to be issues, please contact Stephanie Waloch at swaloch@nd.gov or Cindy Sheldon at cmsheldon@nd.gov.

   Additional Discussion:

   Provider asked how often these are filed.

   North Dakota Medicaid send updates to Sanford Medicaid Expansion every business day except for State holidays.

   Provider asked how it works for out of network benefits.

   North Dakota Medicaid Recipients need to be enrolled in both North Dakota Medicaid and Sanford Medicaid Expansion.

Provider Relations

1. We have concerns with the process of communicating with Provider Relations: a. Call back messages from Provider Relations are sometimes left after regular business hours so that there is a chance of talking to the rep; b. it states to leave a detailed message, however numerous times the call back message does not address the message left. This process has become somewhat cumbersome and

inefficient. Would it be possible to have an e-mail option of communication or having someone answer the phone when calling Provider Relations?

Response:

When calling Provider Relations, providers are allowed to leave up to 3 recipients per message. We recommend that if a provider has more than 10 recipients total they fax a status request into Provider Relations and they will research the request and get back to the provider as soon as possible. This helps reduce the phone request backlog. Calls are returned within 24-48 hours depending on the volume of calls. Calls are returned in the order they are received.

- **Fax number: 701-328-1544**

Provider Relations processes calls Monday thru Friday until 5:00 pm only.

If provider's voicemail does not have the necessary information or is unclear, Provider Relation staffs are unable to leave a detailed voicemail.

Provider Relations ask that providers please leave the following information when their voicemail message:

- **Recipient name and number**
- **Provider name and number**
- **DOS**
- **Billed amount**
- **Question or Request (be specific)**

Provider Relations does have an email address for Third Party Billers. Please allow 7-10 business days to respond to email inquiries.

- **www.NDHin .org/services**

Additional Items:

- **Effective December 1, 2014, DME providers will be required to use the current PRIOR AUTHORIZATION REQUEST form SFN 1115 (8-2014).**

  If outdated versions are submitted for review after 12-1-2014, the request will be returned to the provider for resubmission using the current form located at www.nd.gov/eforms.

Additional Discussion:

Provider asked why they need the Physician Medicaid number.

The current MMIS system only recognizes the North Dakota Medicaid number.

Provider Integrity/Provider Enrollment is research the issue of Locum Tenen physicians and enrollment with North Dakota Medicaid.

- **The Department reminds providers to check Medicaid Provider's Update web page for important updates regarding policy changes, billing and coding guidance etc.**

  http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-updates.html

- **If an item has an assigned HCPC code but does not appear on the DME fee schedules it is considered as a non – covered item and using a misc code would be incorrect.**

- **Code E1028 is used for:**
  1. **Swing away hardware used with remote joysticks or touchpads,**
  2. **Swing away or flip-down hardware for head control interfaces E2327 and E2330.**
  3. **Swing away hardware for an indicator display box that is related to the multi-motor electronic connection codes E2310 or E2311.**

- **Code E1028 is not to be used for swing away hardware used with a sip and puff interface (E2325) because the swing away hardware is included in the allowance for that code. Code E1028 is not to be used for hardware on a wheelchair tray (E0950). Do not use E1028 in addition to E1020 (Residual limb support system) as it includes the swing away hardware.**

Electronic Signatures

Documentation submitted to ND Medicaid must be signed by the practitioner performing the service. All medical record entries must be legible and complete, dated and timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided consistent with organization policy.

Electronic signatures in medical records will be accepted in the following format:

- **Chart 'Accepted By' with provider's name**
- **'Electronically signed by' with provider's name**
- **'Verified by' with provider's name**

- **'Reviewed by' with provider's name**
- **'Released by' with provider's name**
- **'Signed by' with provider's name**
- **'Signed before import by' with provider's name**
- **'Signed: Dr. _____' with provider's name**
- **'Digitized Signature" Handwritten and scanned into the computer**
- **'This is an electronically verified report by Dr. _____'**
- **'Authenticated by Dr._____'**
- **'Authorized by: Dr. _____'**
- **'Digital Signature: Dr. _____'**
- **'Confirmed by' with provider's name**
- **'Closed by' with provider's name**
- **'Finalized by' with provider's name**
- **'Electronically approved by' with provider's name**
- **'Signature Derived from Controlled Access Password'**

Unacceptable Signatures are:

- **Dictated, but not read**
- **Signed, but not read**
- **Auto-authentication**
- **Rubber Stamp Signatures *(Source: 7/29/08: MLN Matters SE0829 CMS States: "Stamped signatures are NOT acceptable on any medical record.")***

If there is no signature appended to medical record documentation, claims will be denied for no signature.

Span Dates

The current MMIS cannot be modified to accommodate overlapping spans of dates. If a claim is denied as a duplicate, it will need to be adjusted with notes indicating it is not a duplicate and explaining the early fill. Providers should not modify dates of service on the claim. The correct dates of service need to be billed.

When billing claims to North Dakota Medicaid, be sure to include the "5-day leeway" in box 19. By supplying this information on each claim it will prevent the claim from denying and the need for an adjustment.

The current MMIS is not able to accommodate overlapping span dates. This issue will more than likely be carried over to the new system.
It is very important that when submitting the CMS-1500 form for payment, the provider include the notation "5 day leeway" in box 19 on the form, or it will be denied as a duplicate service.

NDMA cautions providers that the "5 day leeway" remark cannot be used for every month as this will result in exceeding the limits of supplies.

When submitting a 1500 form the prior authorization number(s) must be on the claim form, not attached behind the claim.

NCCI and MUE

National Correct Coding Initiative (NCCI) – North Dakota Medicaid applies the following billing requirements for submitting claims for reimbursement:

Procedure codes that are denied by NCCI procedure-to-procedure edits are not separately payable by Medicaid as they are included in the payment for the base equipment or most comprehensive procedure/service or are not covered when reported together if they are provided to the patient on the same date of service. It is against policy for any provider to resubmit claims for denied procedure codes on a different date of service in an attempt to avoid NCCI edits. If this is discovered at any time by the department all items paid on another date of service will be recouped and the provider may be put on prepayment review and/or reported to the Office of Inspector General's Program Integrity Unit.

ALL Services
1) All items submitted on a prior authorization for reimbursement must be billed on the same date of service they are actually provided.
2) The date of service that the procedure is rendered/delivered is the date of service on the claim (excludes supplies with grace period).
3) ALL Base Procedures along with ANY related services, options, or accessories are to be billed with the date of service they are rendered or delivered.

For DME: Replacement parts are the only items that may be reported on a date of service that is not the same as the delivery date of the base equipment.

****The Department does not review NCCI edits during the Prior Authorization process. Items approved by the Department on a prior authorization that fail NCCI edits are not separately payable. The DME Provider is responsible for reviewing the files to determine if it is appropriate to request approval for the items. NCCI edits have been in place for Medicare for several years. This process is no different and providers should be familiar with the edits before requesting approval and submitting claims.**

4) Federally Mandated Maximum Units

The MUE file is the maximum number of units expected to be reported on a single date of service for a single beneficiary for most situations.

****ND Medicaid follows the Medicaid Only NCCI and MUE methodology that can be found at www.medicaid.gov .**

The difference between Medicare and Medicaid is the editing logic.

- **2014 DME Fee Schedules are now posted.**

Program Integrity

The Recovery Audit Contractor (RAC) will be looking at the following areas specific to DME:

- **Recipient not eligible**
- **Provider not enrolled**
- **Duplicate claim payments**
- **Recipient had other insurance**
- **Prior Authorization number missing on claim, for those items that require a prior authorization, or an old prior authorization number is used after a new prior authorization number has been issued.**
- **Missing or incomplete documentation (Certificate of Medical Necessity, Physician Orders, etc.).**
- **Physician Orders not signed by the physician (I mention this one separately because missing signatures seem to be a consistent problem in audits).**
- **Billing for services included in the rental rate**
- **Rental charges being billed after the rental period**

The Department cannot emphasis enough, the importance of documentation and making sure it is correct, that prior authorizations are in place and the correct prior authorization number is on the billing form, physician orders are signed, quantities provided are what is authorized, the correct equipment is supplied as authorized, and so on.

The RAC will be looking at dates of service of 1/1/2011 thru 12/31/2013.

The RAC will be requesting records in most cases to verify that the documentation is correct and complete for the claims that are being reviewed.

Providers need to follow the instructions on the letter sent from the RAC, questions should be directed to the RAC.

If the provider receives a recovery letter and they appeal, the initial 2 informal appeals will be reviewed by the RAC and their medical director. Instructions will be included in the recovery letter. Providers are encouraged to exercise the informal process in order to address issues at the lowest level possible.

If a provider still disagrees they can appeal using State Form Number (SFN) 168. The formal appeal must be received by the state within 30 days of the date on the final appeal decision letter from the RAC.

Questions regarding the RAC or other audits may be addressed to Larry Stockham, lstockham@nd.gov , Medicaid Program Integrity Audit Coordinator.

The Department commends the DME Providers for their continued efforts in submitting "clean" prior authorization requests, resulting in an increased efficiency processing prior authorization requests.

Thank you for your outstanding continued service and dedication to our North Dakota Medicaid recipients!!!